Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name
HOUSTON ISD

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-06-2354-01

MFDR Date Received
December 2, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are two copies of additional documentation relevant to this fee dispute. Also enclosed are two copies of EOB's from other carriers, which show a higher rate of reimbursement, consistent to our usual and customary. We are requesting that our claims be paid at usual and customary."

Amount in Dispute: $34,658.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent asserts it paid a fair and reasonable rate to the Requestor for all services rendered to the Claimant, per Tex. Labor Code §413.011(b). The Requestor has not met its burden to prove its bills were within the parameters contemplated by the Act, and thus merits no further reimbursement."

Response Submitted by: Harris & Harris, 5300 Bee Cave Road, Building III, Suite 200, Austin, Texas 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 2005	Inpatient Hospital Services	$34,658.46	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- F – Reduction According to Fee Guidelines

Findings

1. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264. Review of the submitted documentation finds that the length of stay was 1 day. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 1 day yields a reimbursement amount of $1,118.00.
2. Additionally, per §134.401(c)(4)(A)(i), implantables (revenue codes 275, 276, and 278) shall be reimbursed at cost to the hospital plus 10%. Review of the submitted records finds that the health care provider billed revenue code 278 in the amount of $4,600. Review of the submitted medical reports and supply invoices finds that:
   - Two Smith and Nephew Twinfix AB 5.0 anchors with 2 ultrabraid sutures were documented; however, the requestor did not submit a purchase order invoice or other documentation to support the cost to the hospital of these disputed implantables. Therefore, reimbursement cannot be recommended.
   - One 5.00 mm Bio-Corkscrew Suture Anchor with #2 FiberWire was documented. The requestor submitted a purchase order invoice supporting that the cost to the hospital of this implantable was $250.00. 10% of this amount is $25.00, yielding a reimbursement amount of $275.00.
3. The total recommended reimbursement for the services in this dispute is $1,393.00. This amount less the amount previously paid by the insurance carrier of $1,745.00 leaves an amount due to the requestor of $0.00. No additional reimbursement is recommended for the services in dispute.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	July 26, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.